

9207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Margaret</u> Last <u>Mary Albers</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1886</u>
9. AGE (In years, last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Kohles</u>		14. MOTHER'S MAIDEN NAME <u>Barbara J. Hahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>daughter - Mary Harper</u>		Address <u>Jarrettsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident (thrombosis)</u> <u>4437</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>yes</u> INTERVAL BETWEEN ONSET AND DEATH <u>Seizure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 August</u> , 19 <u>66</u> , to <u>present</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>27 August</u> , 19 <u>66</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James F. White Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Jarrettsville, Maryland</u> DATE SIGNED <u>8/1/66</u>	
PHYSICIAN'S NAME (Type) <u>James F. White Jr. M.D.</u>		<u>Jarrettsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>AUG 2 '66</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 BOSTON, MASS.
 JAN 10 1917

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Time of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
LEONARD, JACK		M		35		JAN 10 1917		BOSTON, MASS.		JAN 10 1917		BOSTON, MASS.		HEART DISEASE		10:00 AM		J. H. BROWN		J. H. BROWN		J. H. BROWN	
Occupation		Marital Status		Previous Illness		Last Seen Alive		Buried		Burial Place		Burial Date		Burial Time		Burial Signature		Burial Date		Burial Time		Burial Signature	
Carpenter		Married		None		JAN 10 1917		Yes		CATHOLIC CHURCH		JAN 10 1917		10:00 AM		J. H. BROWN		JAN 10 1917		10:00 AM		J. H. BROWN	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	

LEONARD, JACK 3505 HINGWOOD AVE.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09158

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. LENGTH OF STAY IN lb <u>4 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Older Point Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rhonda Josephine Anderson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1922</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Virgil T. Steyer</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Grimm</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-16-3584</u>		17. INFORMANT <u>William Anderson</u>		Address <u>Abingdon, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>25 W chest</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with rifle</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p.m. <u>8-2-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Abingdon Harford MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 8-2-60 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bel Air, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Aug 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leighton Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Garrett, Maryland.</u>	
23. FUNERAL DIRECTOR <u>Howard K. Thompson</u>				ADDRESS <u>Abingdon, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09159

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEWARTSTOWN	
d. STREET ADDRESS 75X-3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle MELINDA Last AYRES		4. DATE OF DEATH Month August Day 2 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 7, 1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carman		14. MOTHER'S MAIDEN NAME MARY CARRIE SNYDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 173-32-6148	
17. INFORMANT Mrs. Isidore Mackay		Address Stewartstown Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) hypertensive arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days > 5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month July Day 28 Year 1960 Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28, 1960 to Aug 2, 1960 , that (I) (we) last saw the deceased alive on Aug 2, 1960 , and that death occurred at 6:28 A.M., from the causes and on the date stated above.			
22a. SIGNATURE B. J. Plunkett Jr.		22b. DATE SIGNED 8-2-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		8-4-1960	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
STEWARTSTOWN		STEWARTSTOWN, YORK CO., PA.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Osburn		ADDRESS Stewartstown Pa.	
25a. REC'D BY REGISTRAR DATE AUG 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Fries	

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CERTIFICATE OF DEATH

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MADE IN

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9188

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09161

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>48 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	
3. NAME OF DECEASED (Type or print) <u>IDA</u> First <u>A</u> Middle <u>BEST</u> Last		4. DATE OF DEATH <u>August 18</u> 19 <u>60</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1880</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Van Valkenburg</u>		14. MOTHER'S MAIDEN NAME <u>Elia Briggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>G. ARNOLD PFAFFENBACH</u> Address <u>HAVRE DE GRACE MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (bacterial)</u> 422.2 DUE TO <u>Chronic nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic myocarditis</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> 19 <u>60</u> to <u>8/17</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG 22, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EAST GREENBUSH CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>RENSSELAER CO. N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAVRE DE GRACE MD.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 23 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CC-100-1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9209

CERTIFICATE OF DEATH

09162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pylesville		c. LENGTH OF STAY IN 1b 13 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle Campbell Last Campbell		4. DATE OF DEATH Month Aug. Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1888
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Rocks, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Campbell		14. MOTHER'S MAIDEN NAME Elizabeth Amos	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-8848	
17. INFORMANT Mrs. Mary J. Campbell		Address Pylesville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma. DUE TO Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mos. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 58 , to 24 Aug. , 19 60 , that I last saw the deceased alive on 23 Aug. , 19 60 , and that death occurred at 12:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jarrettsville, Md. DATE SIGNED Thos. A. E. Mosley, M.D.			
ACTUAL SIGNATURE Thos. A. E. Mosley, M.D.			
PHYSICIAN'S NAME (Type) Jarrettsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/1960	
22c. NAME OF CEMETERY OR CREMATORY William Watters		22d. LOCATION (City, town, or county) (State) Coopstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz		24a. REC'D BY REGISTRAR AUG 26 '60	
ADDRESS Jarrettsville Md.		24b. REGISTRAR'S SIGNATURE Conrad S. Kraus	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth	
5. Date of death		6. Place of death		7. Cause of death		8. Manner of death	
9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of coroner		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury	
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1. Name of deceased

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3. Age

4. Date of birth

5. Date of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9189

09163

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de Grace</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ZION</u> d. STREET ADDRESS <u>NORTH EAST Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Thomas CARPENTER</u> First Middle Last			4. DATE OF DEATH <u>August 4 1960</u> Month Day Year				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Nov. 24, 1954</u> Yrs. Months Days Hours Min.		9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS. lost birthday) <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child.</u>			
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Kenneth CARPENTER</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Benjamin</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kenneth Carpenter North East, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Glomerulonephritis</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Rheumatic Heart Disease & Congestive Failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> 19<u>60</u>, to <u>Aug 4</u> 19<u>60</u>, that (I) (we) last saw the deceased alive on <u>Aug 4</u> 19<u>60</u>, and that death occurred at <u>9A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. H. Richards Jr.</u>			22b. DATE SIGNED <u>8/4/60</u>				
22c. PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr.</u>			22d. ADDRESS <u>Port Deposit Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-7-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem. (Near) Port Deposit Md.</u>			
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. McNullan</u>					
25a. REC'D BY REGISTRAR DATE <u>AUG 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Huns</u>					

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9190

09164

Item 9 Film 6269 8-19-60 et

1. PLACE OF DEATH a. COUNTY <i>Havre de Grace</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i> c. LENGTH OF STAY IN 1b <i>8 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Havre de Grace Memorial Hosp.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Havre de Grace</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i> d. STREET ADDRESS <i>1832 S. Market St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Luther</i> Middle <i>H.</i> Last <i>Chance</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 15, 1876</i> 9. AGE (In years, months, days, hours, minutes) <i>83 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Butcher</i>	
11. BIRTHPLACE (State or foreign country) <i>Havre de Grace, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>William Chance</i>		14. MOTHER'S MAIDEN NAME <i>Rusan Phillips</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. Melvin Mackin</i>		Address <i>800 S. Adams St. Havre de Grace, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>422.01</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>A. S. C. V. D.</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lobar pneumonia, left lower lobe</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug. 3rd, 1960</i> to <i>Aug. 11th, 1960</i> that (I) <i>met</i> last saw the deceased alive on <i>Aug. 11th, 1960</i> and that death occurred at <i>12 P.</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Loo, M.D.</i>		22b. DATE SIGNED <i>8/11/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		22d. ADDRESS <i>Havre de Grace, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/14/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Havre de Grace, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Hume</i>		25a. REC'D BY REGISTRAR <i>AUG 16 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

09165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 1, Bel Air				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles First Middle Last				4. DATE OF DEATH August 28, 1960 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1893	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Grayson Co, Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Crop			
13. FATHER'S NAME Joseph P. Corner				14. MOTHER'S MAIDEN NAME Mrs. Charles Corner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 11-11-11			
17. INFORMANT Mrs. Charles Corner Address Bel Air Md				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 260X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 7 days ? 15 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Willard P. Hudson M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Aug 31, 1960				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial				22d. LOCATION (City, town, or county) (State) Harford Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey				24a. REC'D BY REGISTRAR SEP 7 '60			
ADDRESS Washington Md				24b. REGISTRAR'S SIGNATURE Robert L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

<div>Item 20b Film 271 9-30-60 ans</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9211 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> <div>09166</div>															
1. PLACE OF DEATH a. COUNTY <u>Harpard</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY in 1b <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RD 2</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harpard</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air (Cressey Creswell)</u> d. STREET ADDRESS <u>RD 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>Fred Eugene Cox</u>		4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1960</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June, 1, 1928</u>		9. AGE (In years last birthday) <u>32</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Herdsmen</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farm</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>			
13. FATHER'S NAME <u>John Cox</u>				14. MOTHER'S MAIDEN NAME <u>Laura Kirby</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>231-32-5059</u>		17. INFORMANT <u>Louise M. Cox</u> Address <u>Bel Air R.D., #2 Md.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Traumatic intracranial hemorrhage</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (e), stating the underlying cause last. DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-auto type</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>8:30</u> p.m. <u>8-30, 1960</u>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cross Farm</u>		20f. (City or town) <u>Bel Air</u>		(County) <u>Harper</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>		DATE SIGNED <u>8-30-60</u>	
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>				EXAMINER'S NAME (Type) <u>Gerald C. Palmer MD</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>Aug. 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Vaughan-Guyann F.H.,</u>				22d. LOCATION (City, town, or country) (State) <u>Galax, Grayson Co., Virginia.</u>					
23. FUNERAL DIRECTOR <u>Howard K. Brown</u>				ADDRESS <u>Abingdon, Md.,</u>				24a. REC'D BY REGISTRAR <u>SEP 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09167

9185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME OF DECEASED CORNER WALLACE + JOHN STS.				d. STREET ADDRESS CORNER WALLACE + JOHN STS.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) KATHARINE S. DAIGER				4. DATE OF DEATH AUGUST 18 1960			
5. SEX F		6. COLOR OR RACE W.		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 22, 1892	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publicity Director				10b. KIND OF BUSINESS OR INDUSTRY Charity Funds		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William A. Boblitz				14. MOTHER'S MAIDEN NAME Sarah H. Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. 212-32-2840		17. INFORMANT (Son) Mr. John A. Daiger Address 121 WALLACE STREET BEL AIR, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X APOPLEXY DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DIABETES							INTERVAL BETWEEN ONSET AND DEATH LESS THAN 1 HR. 3 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PLEURISY, LEFT STARTED 8/16/60							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept , 19 56 , to 17 AUG , 19 60 , that I last saw the deceased alive on 17 AUG , 19 60 , and that death occurred at 8:14 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. P. Sidwell M.D.				ADDRESS (Street, city or town, state) 401 Franklin St. Bel Air, Md. DATE SIGNED 18 AUG 1960			
PHYSICIAN'S NAME (Type) H. P. SIDWELL M.D.				ADDRESS 401 FRANKLIN ST BEL AIR, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 20, 1960		22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. BEL AIR, Maryland				24a. REC'D BY REGISTRAR DATE AUG 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fenn	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9191

09168

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve De Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>288 N. Main Street</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph H. Di Giovanni</i>		4. DATE OF DEATH <i>Aug. 3, 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 27, 1916</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tavern Keeper</i>	
11. BIRTHPLACE (State or foreign country) <i>Conn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Frank Di Giovanni</i>		14. MOTHER'S MAIDEN NAME <i>Jenny Sablone</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>128-05-8319</i>	
17. INFORMANT <i>Ann Di Giovanni (wife)</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> <i>153.9</i> DUE TO <i>Ca of large bowel & frequent pelvis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i> <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>8-3</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>8-3</i> , 19 <i>60</i> and that death occurred on <i>8-3</i> , 19 <i>60</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Wm. K. Brendle</i>		22b. DATE SIGNED <i>8-4-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>William K. Brendle</i>		22d. ADDRESS <i>Harve De Grace, Md.</i>	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <i>Burial</i>	23b. DATE THEREOF <i>Aug. 6, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Erin Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Harve De Grace, Md. Rural</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson & Son</i>		ADDRESS <i>Perryville, Md.</i>	
25a. REC'D BY REGISTRAR <i>AUG 5 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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1918

CERTIFICATE OF DEATH

1918

(M)

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to discern but appear to include:]

... of ...
... born ...
... died ...
... cause of death ...
... signed ...
... registrar ...
... date ...
... place ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09169

9212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman (Rural)</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Perryman, (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 133</u>				d. STREET ADDRESS <u>Box 133</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALLEN ARLINGTON DORSEY</u>				4. DATE OF DEATH Month Day Year <u>August 30 19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 18, 1879 81</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Trackman (Ret) Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Allen R. Dorsey</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Wilson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>717-07-5413</u>				17. INFORMANT <u>Lillie R. Dorsey, Box 133, Perryman, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Emphysema</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/13</u> , 19 <u>60</u> , to <u>8/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>60</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury, M.D.</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St. Sept. 2, 1960</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury, M.D. Har re de Grace, Md.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	
24c. REC'D BY REGISTRAR <u>SEP 6 '60</u>				24d. REGISTRAR'S SIGNATURE			

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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9213
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09170

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground		d. STREET ADDRESS 321-D Watervliet Street	
3. NAME OF DECEASED (Type or print) First Infant Middle Male Last DOUTHIT		4. DATE OF DEATH Month August Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1960
9. AGE (In years lost birthday) yrs. 10 Months 10 Days 40 Hours 40 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Pfohl Douthit		14. MOTHER'S MAIDEN NAME Christine Missouri Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address 321-D Watervliet Aberdeen, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure and cardiac failure 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gross prematurity and immaturity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 hrs 40 min		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from August 4, 1960 to August 5, 1960 , that we (we) lost saw the deceased alive and August 5, 1960 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas J Fraher MD		22b. DATE SIGNED Aug 5, 1960	
22c. PHYSICIAN'S NAME (Type) THOMAS J FRAHER, MD, FMO		22d. ADDRESS US Army Hospital, Aberdeen Proving Ground, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 8, 1960	
23c. NAME OF CEMETERY OR CREMATORY Post Cemetery		23d. LOCATION (City, town, or county) (State) Aberdeen Proving Gr Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur B. Frank		25a. REC'D BY REGISTRAR DATE AUG 16 '60	
ADDRESS Aberdeen, Md.		25b. REGISTRAR'S SIGNATURE Arthur B. Frank	

00170

CERTIFICATE OF DEATH

00170



Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		10/10/1900		New York		New York		Heart Disease		New York		10/10/1950		J. Smith		A. Brown	
Occupation		Marital Status		Education		Religion		Race		Color		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Teacher		Married		High School		Catholic		White		White		10/10/1950		10:00 AM		New York		J. Smith		A. Brown	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
10/10/1950		10:00 AM		New York		J. Smith		A. Brown		10/10/1950		10:00 AM		New York		J. Smith		A. Brown		10/10/1950	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9192

09171

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE		c. LENGTH OF STAY IN 1b 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital		d. STREET ADDRESS 1 330 South Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN B. DULANEY		4. DATE OF DEATH August 3 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3 12/27/84
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. BARNARD		14. MOTHER'S MAIDEN NAME Josephine Dingee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *** ** *	
17. INFORMANT Mrs. John Archer		Address 330 S. Main St. Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Pneumonitis ② left hemiplegia due to cerebral thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28th, 1960 to Aug. 3rd, 1960 that (I) (we) last saw the deceased alive on Aug. 3rd, 1960 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward C. Loo, M.D.		22b. DATE SIGNED Aug. 4th, 1960	
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Harve de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/6/60	
23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		23d. LOCATION (City, town, or county) (State) Perryman, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		25a. REC'D BY REGISTRAR Tarring Funeral Home Aberdeen, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE AUG 8 '60	

0192

(M)

Maryland

Del. St.

320 South Main

12/27/01

Area

Hospital

Director

Del. St.

Del. St. Health Officer

No.

100-10000

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

Del. St. Health Officer

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9193

09172

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>La Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>1979 1/2 Port road Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Emeal</u> First <u>Mike</u> Middle <u>Galler</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	11. BIRTHPLACE (State or foreign country) <u>N. J.</u>
13. FATHER'S NAME <u>John GALLER</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>227-16-3560</u>	17. INFORMANT Address <u>Marie Kelly 2145 Main St. Bel Air, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Coronary Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis of CV Disease</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>6 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculosis pneumonia</u> <u>002X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 16,</u> 19 <u>60</u> , to <u>Aug. 18,</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 18</u> 19 <u>60</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Ralph Horky</u>		22b. DATE SIGNED <u>Aug. 19, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>		22d. ADDRESS <u>Churchville Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 20, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u>	
ADDRESS <u>Abingdon, Md.,</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

12

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

9194

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09173

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Phillip Hines</u>				4. DATE OF DEATH <u>8</u> Month <u>25</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16 1908</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>P. S. Hines</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Wayne</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Charlotte Hines wife</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>auto Cardiac Failure</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> <u>1960</u> to <u>8-25</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>8-25</u> <u>1960</u> , and that death occurred at <u>3:45</u> P. M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward J. Simon</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Simon</u>				22d. ADDRESS <u>Harre De Grace, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Harre De Grace Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				25a. REC'D BY REGISTRAR <u>AUG 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

BP

0113

WESTLAND AIR DETAILING OF DEATH
OFFICE OF THE DISTRICT ATTORNEY
STATE OF CALIFORNIA
CERTIFICATE OF DEATH

0113



Handwritten signature and text at the bottom of the page, likely a declaration or attestation.

9214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Beecher</u> First <u>H.</u> Middle <u>H.</u> Last <u>House</u>		4. DATE OF DEATH <u>August 9</u> 19 <u>60</u> Month <u>August</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1874</u> yrs. <u>86</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chester Co., Penna., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David H. House</u>		14. MOTHER'S MAIDEN NAME <u>Hannah E. Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Miss Bessie House</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Condition</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>✓</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>✓</u> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>60</u> , to <u>Aug 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 9</u> , 19 <u>60</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. J. Snodgrass</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore MD</u>	
PHYSICIAN'S NAME (Type) <u>F. J. Snodgrass</u> M.D.		DATE SIGNED <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 13, 1960 Mt Taber</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Co., MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> <u>Harford MD</u>		24a. REC'D BY REGISTRAR <u>AUG 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

1

Page 4

law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09175

9195

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY CECIL ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE		c. LENGTH OF STAY IN 1b 36 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS NORTH EAST			
3. NAME OF DECEASED (Type or print) John First Randolph Middle Janney Jr Last				4. DATE OF DEATH August 7 19 60 Month Day Year			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-11-1906	9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPECIAL AGENT		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN RANDOLPH JANNEY				14. MOTHER'S MAIDEN NAME FRANCES GALATION			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 136-09-8525		17. INFORMANT Address John R. Janney III Charlottesville Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Rupture and Interventricular Septum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aneurysm of interventricular septum (c) Myocardial infarction of anterior wall and PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 36 day						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 2 19 60 to August 7 19 60 , that (I) (we) last saw the deceased alive on Aug 7 19 60 and that death occurred at 230 AM, from the causes and on the date stated above.							
22a. SIGNATURE Edward C. Loo, MD				22b. DATE SIGNED 8/8/60			
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, MD				22d. ADDRESS Haure de Grace, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-11-1960		23c. NAME OF CEMETERY OR CREMATORY BAY VIEW METH		23d. LOCATION (City, town, or county) (State) NORTH EAST CECIL MD	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant North East Md				25a. REC'D BY REGISTRAR AUG 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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9196
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09176

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE		c. LENGTH OF STAY IN 1b 18 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 07 HARFORD Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ellis LE ROY JONES		4. DATE OF DEATH Month Day Year August 10 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 25, 1881
9. AGE (In years lost birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Jackson Jones	
14. MOTHER'S MAIDEN NAME MARY HARTIN ESHLEMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 216-10-6789		17. INFORMANT Address Cladya M. Jones, Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO 201X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hodgkin Disease, quered. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 8-10 19 60 , and that death occurred at 11:30 M., from the causes and on the date stated above.			
22a. SIGNATURE Wm. K. Prender		22b. DATE SIGNED 8-11-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/13/1960	
23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		23d. LOCATION (City, town, or county) (State) Rising Sun Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rolph M. Reed		25. REC'D BY REGISTRAR Ang 15 '60	
ADDRESS Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9215 CERTIFICATE OF DEATH

09177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air RURAL</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Red Pump Road</u>		d. STREET ADDRESS <u>Red Pump Road</u>	
3. NAME OF DECEASED (Type or print) <u>Bunford E Kane</u> First Middle Last		4. DATE OF DEATH <u>August 28 1960</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-04</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>With County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES KANE</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Meridith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (wife) <u>Mrs. Willie Mae Kane</u> Address <u>Rd 3 Box 383 Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C/V disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-20</u> , 19 <u>60</u> , to <u>8-28</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8-27</u> , 19 <u>60</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lerald E Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>8-28-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerold C Palmer M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 31, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harf. Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St. BEL AIR, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 31 1960</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>

01177

CERTIFICATE OF DEATH

01177

Age 65

MALE

WHITE

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Age 65

MALE

WHITE

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Age 65

MALE

WHITE

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Age 65

MALE

WHITE

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Age 65

MALE

WHITE

Single

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

Married

Widowed

Divorced

Never married

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9216

09178

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewis Lane - General Del.</u>				c. LENGTH OF STAY IN 1b <u>about 30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Havre de Grace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>L.</u> Last <u>Kell</u>				4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>27</u>		11. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>30</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Joe Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mr. Robert Arthur Kell</u>				Address <u>Lewis Lane, Havre de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Renal Insufficiency</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> , 19 <u>60</u> , to <u>Aug. 27</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug. 24</u> , 19 <u>60</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury</u>				22b. DATE SIGNED <u>8/27/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution St. Havre de Grace, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-30-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock, Havre de Grace, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							

MEDICAL CERTIFICATION

2516

CERTIFICATE OF DEATH

2516



FILED

NOV 10 1916

W. A. R. H. S.

NOV 10 1916

NOV 10 1916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9197

CERTIFICATE OF DEATH

09179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHY NOREEN KELLY		4. DATE OF DEATH Month August Day 10 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1956
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Glenn R. Kelly		14. MOTHER'S MAIDEN NAME Irene Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ** **	
17. INFORMANT Glenn R. Kelly, 211 Darlington Ave.		Address Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 31, 1959 , to Aug 10, 1960 , that I last saw the deceased alive on Aug 10, 1960 , and that death occurred at 11:15 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. DATE SIGNED 8-11-60 ACTUAL SIGNATURE B. J. Plunkett Jr. M.D. PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D. Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/60	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Tarring Funeral Home, Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9217

CERTIFICATE OF DEATH

09180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARLINGTON Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARLINGTON Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First PAUL Middle RUFUS Last KNIGHT				4. DATE OF DEATH Month 8/ Day 15/ Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1901		9. AGE (In years lost birthday) yrs. 58	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR LEADER				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVE.		11. BIRTHPLACE (State or foreign country) HARFORD CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HUGH R. KNIGHT				14. MOTHER'S MAIDEN NAME SARA JANE TROUTNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-05-1582		17. INFORMANT MRS. BESSIE KNIGHT DARLINGTON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Attack 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Hard work							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. NO 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1960 to Aug. 15, 1960 , that I last saw the deceased alive on Aug. 15, 1960 , and that death occurred at MD from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) F.P. Smolgrass M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Darlington MD 8/16/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/1960		22c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEM.		22d. LOCATION (City, town, or county) (State) DARLINGTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Carmon E. Mullen				ADDRESS RISING SUN, MD.		24a. REC'D BY REGISTRAR AUG 18 '60	
				24b. REGISTRAR'S SIGNATURE Carmon E. Mullen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9217

Reg. Dist. No.

Place of Death

Residence

Place of Birth

Age at Death

Sex

Color

Cause of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09181

Items 3, 13, 14 fill in MG 270 9-6-60 et

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millers</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DoA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>06X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>J</u> Last <u>Matthews</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wt.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/4/04</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTR.</u>	9. AGE (In years, last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Alexander Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Mannie Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-01-2857</u>	
17. INFORMANT <u>Bel Air</u>		Address <u>MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO (b) <u>8257</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>8257</u> DUE TO (c) <u>8257</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-29-60</u> Hour <u>5</u> <u>5</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 152</u>	20f. (City or town) <u>Fallston</u> (County) <u>Harford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>MD</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>MD</u>	
		Address (Street, city, town, or county) <u>829-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>	22d. LOCATION (City, town, or country) <u>BALTIMORE</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR <u>L. F. EVANS & SON</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '60</u>	
ADDRESS <u>8802 HARFORD RD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

THE JURY
FINDS THAT

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THE JURY
FINDS THAT

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010

010

1/10/1918
100

1
FOR STATE
HEALTH DEPT. *M*
X
TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
I
VS. A15ME
5M 7/59
Now

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09182

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford</i> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Street</i>				c. LENGTH OF STAY IN 1b <i>12 days</i> X			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Bx 299 RD 2</i>				d. STREET ADDRESS <i>1 Bx 299 RD 2</i>			
3. NAME OF DECEASED (Type or print) <i>Dolores J. Mc Lain</i>				4. DATE OF DEATH <i>August 14 1960</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 3 1960</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cornelius Mc Lain</i>				14. MOTHER'S MAIDEN NAME <i>Ernestine Davis</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknwn) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. Cornelius Mc Lain</i> Address <i>Street, Harford</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>763.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Beltz</i> EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>8-14-60</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-16-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Church Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Harford County, md</i>	
23. FUNERAL DIRECTOR <i>Elmer E. Bullock</i> ADDRESS <i>Harford, Md</i>				24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>AUG 22 '60</i>							

071314XV4

9318
1913

100-418
1913

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9199
CERTIFICATE OF DEATH
09183

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>	
c. LENGTH OF STAY IN 1b <u>16 DAYS</u>		d. STREET ADDRESS <u>1553 GILES ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HENRY</u> Last <u>Pitcock</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 17, 1878</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES H. Pitcock</u>		14. MOTHER'S MAIDEN NAME <u>ARABELLE LEIGHT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>214-34-4086A</u>	
17. INFORMANT <u>FLORIE M. Pitcock</u>		Address <u>HAURE DE GRACE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis C.V.D.</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Simian Symptoma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1960</u> , to <u>Aug. 10, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug. 8, 1960</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Don P. Perpoint</u>		22b. DATE SIGNED <u>Aug 10, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Don P. Perpoint MD</u>		22d. ADDRESS <u>610 S. Glenwood Ave. Haure de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>13-AUG-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN CHRISTIAN CH. YARD</u>		23d. LOCATION (City, town, or county) (State) <u>HARFORD Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Madison</u>		25a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>Haure de Grace, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>AUG 15 '60</u>			

1130

(M)

State of New York
County of Albany
City of Albany
I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of Albany, do hereby certify that
on the 12th day of August, 1912
at Albany, New York
died
of
Typhoid Fever
the person whose name is written above in the presence of the undersigned and of the following witnesses:
John J. Smith, Mayor of the City of Albany
James H. Jones, President of the Board of Health
The death was caused by
Typhoid Fever
and was not due to any other cause.
Witness my hand and the seal of the Department of Health at Albany, New York, this 12th day of August, 1912.

9184

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dorsey Street</u>				e. STREET ADDRESS <u>Dorsey Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Fred G. Pitt (Frederick Pitts)</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1895</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Albert Pitt</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Stansbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-4447</u>		17. INFORMANT <u>John Pitt, R.D. 1, Havre de Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis & Fibrosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year ____ 19 ____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July 14, 1960</u> , to <u>Aug 19, 1960</u> , that I last saw the deceased alive on <u>Aug 19, 1960</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u> , M.D.				ADDRESS (Street, city or town, state) <u>569 Revolution St.</u>		DATE SIGNED <u>8/20/60</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury, M.D.</u>				<u>Havre de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. 3, Aberdeen, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09185
Reg. Dist. No.

9219

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Bel Air				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Bel Air,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First TROY Middle ELMER Last POOLE		4. DATE OF DEATH		Month August Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1898	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Poole				14. MOTHER'S MAIDEN NAME Laurie Carico			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-24-0566		17. INFORMANT Mrs. T. Elmer Poole		Address R.D. #1 Bel Air, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis CVD Heart DUE TO (c) 6 yrs							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubital Ulcer							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1939 to Aug 1960 , that I last saw the deceased alive on Aug 29, 1960 , and that death occurred at 6:30 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Ralph Horky				ADDRESS (Street, city or town, state) Churchville, Md. DATE SIGNED 8/30/60			
PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/60		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				24a. REC'D BY REGISTRAR SEP 1 '60		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9200
CERTIFICATE OF DEATH

09186

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>718 Revolution Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen P. Powell</u>				4. DATE OF DEATH <u>Aug. 2, 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1901</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Haley -</u>				14. MOTHER'S MAIDEN NAME <u>Julia Hickey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Mary C. Baker - sister-in-law</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic carcinoma liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>1 week</u> <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 July</u> 19 <u>60</u> to <u>2 August</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>August 2</u> 19 <u>60</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank W. Cloman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2 August 1960</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/4/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Son, Harford, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 4 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

00186

RECEIVED AT THE OFFICE OF THE
SHERIFF OF THE COUNTY OF LOS ANGELES

CERTIFICATE OF DEATH

00200

10

1

CHIEF JURY

MAJOR

8/1/1902
1902

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>M</u> <u>Rocks</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7905 Phila. Road</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rocks Creek State Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK W. ROHRS</u> <u>Frederick W Rohrs</u>		4. DATE OF DEATH <u>August 8</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-76</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri St. Louis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Spanish</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. George A. Rohrs</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO (b) <u>973</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pant hose onto car exhaust</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 30</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rocks Creek State Park</u>		20f. (City or town) <u>Harford</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air MD</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM. BALTIMORE MARYLAND</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC. BALTO. MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 10 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

SSR

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

9201 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1026 MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09188											
1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace d. STREET ADDRESS Webster Village e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAVID JAMES SHIMEK			4. DATE OF DEATH Month August Day 18 Year 19 60			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Sept. 23, 1952			9. AGE (In years last birthday) 7 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Philip J. Shimek			14. MOTHER'S MAIDEN NAME Elizabeth Kilburn		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. *** **			17. INFORMANT Philip J. Shimek Address R.D. 2			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to aspiration of foreign body. 922.5 Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated foreign body			20c. TIME OF INJURY Month, Day, Year 8/18/60		
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street			20f. (City or town) Havre de Grace (County) Harford (State) Md.			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8/22/60			22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery, Baltimore, Maryland			22d. LOCATION (City, town, or country) (State)		
23. FUNERAL DIRECTOR John G. Tarring			24a. REC'D BY REGISTRAR AUG 23 '60			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			DATE SIGNED August 18, 1960		

John G. Tarring

By Phone to Med. Exam.: yellow cap - looked like part of fishing tackle
8/25/60 - a.m.s.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9202
CERTIFICATE OF DEATH

Reg. Dist. No. **09189**

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAV de GRACE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO RURAL d. STREET ADDRESS 07X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROY LEE THOMPSON 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/9/1895 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min.				4. DATE OF DEATH Month 8/ Day 3/ Year 1960			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER RET. 10b. KIND OF BUSINESS OR INDUSTRY U. S. GOV. 11. BIRTHPLACE (State or foreign country) VA. 12. CITIZEN OF WHAT COUNTRY? U.S. A.				13. FATHER'S NAME CONEY THOMPSON 14. MOTHER'S MAIDEN NAME MARGARET MUNCY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 162-09-2159 17. INFORMANT MRS. FRANCES THOMPSON CONOWINGO ID. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 151X DUE TO (b) Metastatic spread from carcinoma of stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from 2 1960 , to 8/3 1960 , that I last saw the deceased alive on 8/3 1960 , and that death occurred at 7 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Neil Taylor M.D. Rising Sun, Md 8/4/60 PHYSICIAN'S NAME (Type) Neil Taylor Rising Sun, Md						22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/6/1960 22c. NAME OF CEMETERY OR CREMATORY PLEASANT GROVE CEM. 22d. LOCATION (City, town, or county) PEACH BOTTOM (State) PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMiller ADDRESS RISING SUN MD.				24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9221

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air (Rural)</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>232 Victory Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Oliver J. Vogel</u> First Middle Last		4. DATE OF DEATH <u>August 22, 1960</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1888</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. Rail Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Butler, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Vogel</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Weber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>716-16-7636</u>	
17. INFORMANT (Name) <u>Mrs. Martha Leader Vogel</u>		18. ADDRESS <u>232 Victory Lane, Bel Air, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>genit arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent & lower limb amputated - et al. Aortic aneurysm</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 Aug., 1960</u> to <u>22 Aug., 1960</u> , that I last saw the deceased alive on <u>22 Aug., 1960</u> , and that death occurred at <u>11:59 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Warren L. Leach, M.D.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 24, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Alto Rest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Altoona, Blair County, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway + Williams St., Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. F...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

Name of Deceased <i>George Noel</i>		Sex <i>Male</i>		Age <i>35</i>	
Date of Death <i>April 1, 1931</i>		Place of Death <i>Home</i>		Cause of Death <i>Heart Disease</i>	
Occupation <i>Teacher</i>		Usual Residence <i>1234 Main St.</i>		Manner of Death <i>Natural</i>	
Signature of Physician <i>[Signature]</i>		Signature of Registrar <i>[Signature]</i>		Signature of Coroner <i>[Signature]</i>	
City <i>Washington, D.C.</i>		County <i>Washington</i>		State <i>D.C.</i>	
Date of Birth <i>March 15, 1896</i>		Place of Birth <i>Germany</i>		Race <i>White</i>	
Married <i>Yes</i>		Spouse's Name <i>[Name]</i>		Date of Marriage <i>[Date]</i>	
Education <i>High School</i>		Religion <i>Catholic</i>		Previous Illnesses <i>None</i>	
Last Seen Alive <i>[Date]</i>		Found Dead <i>[Date]</i>		Time of Day <i>10:00 AM</i>	
Witnesses <i>[Names]</i>		Burial Place <i>[Location]</i>		Burial Date <i>[Date]</i>	
Remarks <i>[Notes]</i>		Remarks <i>[Notes]</i>		Remarks <i>[Notes]</i>	



RECEIVED
MARSHALL STATE DEPARTMENT OF HEALTH
WASHINGTON, D.C.
APR 1 1931

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9203
CERTIFICATE OF DEATH
09191

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>618 BOURBON ST.</u>				d. STREET ADDRESS <u>618 BOURBON ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES MILFORD WARDELL</u>				4. DATE OF DEATH Month Day Year <u>AUG 30 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 3, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		11. BIRTHPLACE (State or foreign country) <u>CECIL CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM WARDELL</u>				14. MOTHER'S MAIDEN NAME <u>ANGELINE JACKSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-4-0855</u>		17. INFORMANT <u>MRS. SALLIE ILEY WARDELL</u>		Address <u>HAVRE DE GRACE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Hypertensive Failure</u> DUE TO (c) <u>Malignant Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>10 years</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 1959</u> to <u>August 30 1960</u> that (I) (we) last saw the deceased alive on <u>Aug 30 1960</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Wolbert MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>				22d. ADDRESS <u>HAVRE DE GRACE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Havre Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9204

CERTIFICATE OF DEATH

Reg. Dist. No.

09192

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamlets Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamlets Chase 24</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>307 D. Washington</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Norris</i> First <i>A.</i> Middle <i>Watson</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 27-1889</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Cliffs Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Alfred Watson</i>		14. MOTHER'S MAIDEN NAME <i>Faith Mull</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Ethel C. Watson</i>		Address <i>307 S. Washington Hamlets Chase Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic heart disease</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/22/</i> 19 <i>60</i> , to <i>8/26/</i> 19 <i>60</i> , that I last saw the deceased alive on <i>8/26/</i> 19 <i>60</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>407 S. Union Ave. Harford Co. Md.</i> DATE SIGNED <i>Arthur S. Hume</i>			
ACTUAL SIGNATURE <i>Arthur S. Hume</i>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harford Co. Md.</i>		24a. REC'D BY REGISTRAR <i>Aug 30 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

1924

(1)

(1)

THIS CERTIFICATE IS TO BE FILED IN THE
OFFICE OF THE REGISTER OF DEATHS
AND IN THE OFFICE OF THE CLERK OF THE
COURT OF THE JUDICIAL DEPARTMENT
IN THE CITY AND COUNTY OF BALTIMORE
AND IN THE OFFICE OF THE CLERK OF THE
COURT OF THE JUDICIAL DEPARTMENT
IN THE CITY AND COUNTY OF BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9205

09193

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE OF GRACE		c. LENGTH OF STAY IN 1b 15 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS RD # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle HOMER Last WEST				4. DATE OF DEATH Month August Day 15 Year 1960			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1904	9. AGE (in years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 3 Days Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ORCHARD WORKER		10b. KIND OF BUSINESS OR INDUSTRY LABORER		11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES WEST				14. MOTHER'S MAIDEN NAME SOFRONA WEST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNK		17. INFORMANT DAREL WEST Address HAUCE DE GRACE RT 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Hypertensive vascular disease (b) ? (c) ?						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/15/60 to 8/15/60 , that (I) (we) last saw the deceased alive on 8/15/60 and that death occurred at 8:40 P M, from the causes and on the date stated above.							
22a. SIGNATURE B. J. Plunkett Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-16-60	
22c. PHYSICIAN'S NAME (Type) B. J. Plunkett Jr.				22d. ADDRESS 			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 8/18/1960		23c. NAME OF CEMETERY OR CREMATORY WEST AND PLUMMER		23d. LOCATION (city, town, or county) (State) ASHE COUNTY N. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington Sr. Hauc de Grace, Md				25a. REC'D BY REGISTRAR 		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9206

CERTIFICATE OF DEATH

09194

Item 9 Baltimore 1-6-60 et

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel de Grace</i>		c. LENGTH OF STAY IN 1b <i>29 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Hella</i> Middle <i>Alice</i> Last <i>Wishon</i>		4. DATE OF DEATH Month <i>August</i> Day <i>20</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 20, 1904</i>
9. AGE (In years last birthday) <i>55</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joan Brewer</i>		14. MOTHER'S MAIDEN NAME <i>Louise Leterman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>228-24463</i>	
17. INFORMANT <i>Self</i> Address <i>Hella A Wishon</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Peritonitis</i> 542.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Rupture of jejunal ulcer + Rupture of duodenal ulcer</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Esophageal ulcer + hemorrhage</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1 Aug</i> 19 <i>60</i> , to <i>20 Aug</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>20 Aug</i> 19 <i>60</i> , and that death occurred at <i>PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Frank D. Hawley</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>August 23, 1960 Bel-Air Memorial Harford Co Md</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>		25. REC'D BY REGISTRAR <i>Aug 25 '60</i>	
ADDRESS <i>Harlingdon</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kram</i>	

3200

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1918

NEW YORK
COUNTY
JAN 15 1918

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09195											
1. PLACE OF DEATH a. COUNTY Harford						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood						c. LENGTH OF STAY IN 1b 2 yrs.,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Army Dispensary Army Chemical Center						e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood					
f. STREET ADDRESS Army Chemical Center						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ARTHUR A. WOTTAWA						4. DATE OF DEATH August 1 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1902		9. AGE (in years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman				10b. KIND OF BUSINESS OR INDUSTRY Post Exchange				11. BIRTHPLACE (State or foreign country) Belleville, Illinois			
12. CITIZEN OF WHAT COUNTRY? U.S.A.,				13. FATHER'S NAME John Wottawa				14. MOTHER'S MAIDEN NAME Elizabeth Bassler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 328-03-4528				17. INFORMANT George Wottawa Address Belleville Ill.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO (c) cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty						M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal						22b. DATE THEREOF Aug. 3, 1960					
22c. NAME OF CEMETERY OR CREMATORY Renner & Sons F.H.,						22d. LOCATION (City, town, or country) (State) Belleville Ill.,					
23. FUNERAL DIRECTOR Howard R. Williams						24a. REC'D BY REGISTRAR Aug 5 '60					
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus						Address (Street, city, town, or county)					

118103

9222

Harford

Harford

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Army Medical Center

Army Medical Center

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August 1

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Harford

Harford

Harford, Illinois

Post Exchange

Harford

Harford, Illinois

Harford

922-03-022

Company, Army, Tennessee

Harford, Illinois

118103

Harford, Illinois

Harford

Harford, Illinois

Harford, Illinois